In the Supreme Court of the United States

OCTOBER TERM, 1976

No. 76-188

BERT SHULLMSON, Director of the Division of Welfare of the State of Missouri; and PAUL R. NELSON, Director of the St. Louis City Welfare Office, *Petitioners*,

vs.

HARIECE LEWIS, *Respondent*.

PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE EIGHTH CIRCUIT

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BERT SHULIMSON, Director of the Division of Welfare of the State of Missouri; and PAUL R. NELSON, Director of the St. Louis City Welfare Office, *Petitioners*,

vs.

HARIECE LEWIS, *Respondent*.

PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE EIGHTH CIRCUIT

Petitioners, Bert Shulimson, Director of the Division of Welfare of the State of Missouri and Paul R. Nelson, Director of the St. Louis City Welfare Office, pray that a Writ of Certiorari issue to review the judgment of the United States Court of Appeals for the Eighth Circuit in the case of *Hariece Lewis* v. *Bert Shulimson, et al.*, No. 75-1735 (Judgment issued April 20, 1976). The mandate of the United States Court of Appeals for the Eighth Circuit in the above cause in *Lewis* v. *Shulimson, et al.*, was stayed pending timely filing and disposition of a Petition for Writ of Certiorari by the Supreme Court of the United States by order entered June 1, 1976.

CITATIONS TO OPINIONS BELOW

The District Court Opinion is reported in 400 F. Supp. 807 (E.D. Mo., 1975). The opinion and order of the District Court are reproduced as Appendix A. The Court of Appeals opinion has not been reported and is reproduced as Appendix B to this petition along with the Order of the Court denying a rehearing.

JURISDICTION

Judgment of the United States Court of Appeals in *Lewis* v. *Shulimson, et al.*, was entered on April 20, 1976. A timely petition for rehearing was denied on May 13, 1976. The jurisdiction of this Court is invoked under 28 USC Section 1254 (1).

QUESTIONS PRESENTED

1. Does 42 USC Section 1396a require that Respondent and the class she represents receive medical assistance benefits from the State of Missouri?

2. Does the 11th Amendment of the United States Constitution bar the federal courts from ordering a state to identify and notify by first class mail a class of persons who have been denied public assistance?

CONSTITUTIONAL PROVISIONS, STATUTES AND REGULATIONS

Constitution of United States, 11th Amendment:

> "The Judicial power of the United States shall not be construed to extend to any suit in law or equity, commenced or prosecuted against one of the United States by Citizens of another State, or by Citizens or Subjects of any Foreign State."

This case involves 42 USC Section 1396a and 45 CFR 248.1, which are reprinted in pertinent part in Appendix C.

STATEMENT OF THE CASE

This case is a class action brought by Plaintiff on her own behalf and on behalf of certain recipients of Federal Supplemental Security Income (hereinafter SSI) benefits in the State of Missouri who are presently ineligible for Medical Assistance under the regulations of the Missouri Division of Family Services, formerly the Division of Welfare.

As part of the State of Missouri's Medicaid program under Title XIX of the Social Security Act, 42 USC Section 1396 et seq., the State of Missouri provides Medical Assistance for needy persons who meet the Missouri's 1972 eligibility requirements for the former programs of Old Age Assistance, Aid to the Blind, and Permanently and Totally Disabled (hereinafter called OAA, AB and PTD, respectively). These former programs were replaced on January 1, 1974 by the Federal SSI program.

Recipients of OAA, AB, and PTD were required to be covered under the State of Missouri's Medicaid program by Section 42 USC 1396a and federal funds were received to help finance the program. Upon the implementation of SSI program the State of Missouri through the Division of Family Services revised the Missouri Medicaid program in regards to this former class of individuals and instituted a program known as Medical Assistance. Under this program persons who meet the January 1, 1972 eligibility requirements for OAA, AB, and PTD and who are also determined to be in financial need receive Medical Assistance benefits. Plaintiff and the class she represents were denied assistance because they did not meet the January 1, 1972 eligibility requirements for either the OAA, AB, or PTD programs.

Plaintiff contended that she belonged to a class of persons that were improperly denied benefits under 42 USC Section 1396a. Plaintiff represents a class consisting of SSI recipients who have been denied medical assistance because they did not meet the January 1, 1972 eligibility requirements for PTD, OAA, or AB. However, she and her class do meet the January 1, 1972 eligibility requirements for General Relief (hereinafter GR). GR is an exclusively state-funded and state-administered program of cash assistance. Medicaid benefits were and are provided to recipients of cash benefits under the GR program but such Medicaid benefits are exclusively paid from state funds.

No evidence was adduced, the cause was submitted to the District Court upon the pleadings, stipulations of fact and the legal briefs of the parties.

Plaintiff contended that the regulations of the Division of Family Services were inconsistent with 42 USC Section

1396 and, therefore, invalid under the supremacy clause of the Constitution of the United States. Plaintiff further contended that the regulations operated to deprive her and those of the class which she represented of equal protection of the law in violation of the 14th Amendment to the U.S. Constitution. The District Court, however, decided this case solely on the basis of the statutory construction.

Contrary to the contentions of Defendants, the District Court by order issued July 9, 1975 and supplemented by an order of July 22, 1975 in the case of *Hariece Lewis* v. *Bert Shulimson, et al.*, No. 74-38C(3) (Hon. H. Kenneth Wangelin), held that the provisions of 42 USC Section 1396a required Defendants to provide medical assistance to the Plaintiff in the class she represents. The Court enjoined the named Defendants from denying such medical assistance and further ordered Defendants to promptly send first class mail notice to all persons in Plaintiff's class who may have been improperly denied medical assistance.

The U.S. Court of Appeals for the Eighth Circuit on April 20, 1976 entered an opinion which affirmed the judgment and orders of the District Court on the basis of the District Court's memorandum opinion and its own comments. Defendants' petition for rehearing was subsequently denied on May 13, 1976.

ARGUMENTS IN SUPPORT OR GRANTING THE WRIT

I

The Court of Appeals' decision interpreting 42 USC 1396a is in direct conflict with and a departure from prior decisions of this Court.

1.

The Court of Appeals in interpreting Section 42 USC 1396a has disregarded this court's prior decisions on the nature of public assistance in the United States.

The decision below is in conflict with the decisions of the Court in *King* v. *Smith*, 392 U.S. 309 (1968); *Dandridge* v. *Williams*, 397, U.S. 471 (1970); *Jefferson* v. *Hackney*, 406 U.S. 535 (1972); and *New York State Department of Social Services* v. *Dublino*, 413 U.S. 405 (1973). The Court of Appeals totally ignored the principle stated in the Court's opinion that welfare is a scheme of cooperative federalism.

The principal issue in this case is whether or not the State of Missouri is required, by the provisions of 42 USC 1396, to provide Medicaid payments to SSI recipients who currently meet the January 1, 1972, State of Missouri General Relief eligibility requirements.

Missouri's General Relief program was on January 1, 1972 and continues to be exclusively state financed and administered and, therefore, free from federal control. The General Relief program in Missouri since its inception has been a program by which the State of Missouri provides assistance to needy persons within the limits of the financial resources available to the state. The criteria for eligibility in this program have constantly changed to reflect the changing needs and financial resources of the citizens of the State of Missouri. As such the distribution of GR funds, eligibility therefor, and benefits incident thereto are matters which were and are exclusively within the domain of the State of Missouri.

On January 1, 1972, and presently, no federal matching funds were or are received by the Missouri Division of Family Services for Medicaid payments made to eligible individuals receiving General Relief benefits, or for the expenses of administering the Medicaid for said General Relief recipients.

Under the former OAA, AB, and PTD programs, for which Plaintiff and the class she represents would not be eligible, the Federal Government provided matching funds. As a prerequisite to the provision of such funds the Federal Government could mandate compliance with certain requirements in the administration of these programs. Further, because of the involvement of Federal funds the Federal Government required that individuals eligible under these programs were also to be eligible for Medicaid. But the Missouri General Relief program was and is generically different from the aforementioned programs; it is exclusively state-financed and therefore free from federal control.

It is one thing to say that the Federal Government can require Medicaid payments to individuals qualifying under federally-funded cash assistance programs; but it is altogether a different thing to require Medicaid payments by the State to individuals who qualify under a cash assistance program that is exclusively state-financed and state-administered The former involves a federal regulation for the distribution of federal funds; the latter entails

an unauthorized and unconstitutional interference with State Government. It cannot be overemphasized that on January 1, 1972, and at the present time no federal matching funds were or are claimed or received by the Missouri Division of Family Services for Medicaid made in behalf of eligible individuals receiving General Relief benefits or for the expenses of administering the Medicaid Program for said General Relief recipients.

Thus, *West* v. *Cole,* 390 F. Supp. 91 (1975), relied on heavily by Plaintiff and the Court of Appeals is clearly distinguishable from the instant case. There the Court held that the Plaintiff was entitled to Medical Assistance benefits by virtue of her eligibility under a state operated AFDC Plan. But the Mississippi AFDC Plan, unlike Missouri's General Relief Program, was federally assisted.

The passage of the SSI Program did not serve to deprive the States of control over State financed welfare programs. The Supremacy Clause of the United States Constitution can be invoked to invalidate a State law only where it can be found that the Federal law was intended to preempt State control, or where a Federal and a State law are in irreconcilable conflict. See e.g. *Florida Lime & Avocado Growers, Inc.* v. *Paul,* 373 U.S. 132 (1963). It has been held that no language in the Supplemental Security Income legislation requires or suggests a total preemption of State responsibility and control of welfare programs. *Fuller* v. *Nassau County Department of Social Services,* 352 NYS 2d 978 (Sup. Ct. 1974).

The courts below held that the language of 42 USC Section 1396a (f) permits the State of Missouri to exclude individuals from medical assistance coverage unless the State of Missouri would have been required to provide assistance to such persons under Missouri's Medicaid Plan in effect on January 1, 1972.

Petitioners contend that the meaning of this statutory language is that States, with passage of the SSI Program, would be required to continue to provide Medical Assistance to those individuals who formerly qualified for OAA, AB, or PTD. The federal statute aforesaid specifically states that no State shall be required to provide medical assistance to any aged, blind or disabled individual unless such State would have been required to provide medical assistance for such individual in January 1, 1972. This clearly means "required" under the provisions of Title XIX in January 1972 and does not mean "required" simply because a State, at its option and at its expense, had furnished such medical assistance incident to a wholly State operated and State financed program such as the Missouri General Relief Program.

On January 1, 1972, Missouri provided medical benefits to General Relief recipients, and further stated in its approved Medical Assistance Plan effective on such date that such assistance was furnished, but Missouri did so of its own volition and in nowise pursuant to a federal mandate. Therefore, as of January 1, 1972, Missouri was not "required" by Federal law to provide medical assistance to General Relief recipients, and the District Court erred in so holding.

Section 1396a (f) does not, as held by the District Court, provide a limited exception to Section 1396a (10) (A). While Section 1396a (10) (A) does provide for coverage of recipients of Supplemental Security Income, Section 1396a (f) provides, in the alternative, for the continuation of Medicaid to the class of aged, blind and disabled who were eligible for assistance under the former federally matched programs.

The language in 1396a (f) clearly evidences that Section 1396a (f) applies to persons other than Supplemental

Security Income recipients. The use of the word "any" and the phrase "within the meanings of Subchapter XVI" demonstrates that Medical Assistance under Section 1396a (f) was intended to apply to any person, not just Supplemental Security Income recipients, who could meet the basic physical criteria of aged, blind and disabled as defined in Subchapter XVI. If Congress had wanted to limit coverage to Supplemental Security Income recipients only, the appropriate language would have then been "all individuals . . . with respect to whom Supplemental Security Income benefits are being paid under Subchapter XVI of this Chapter. 42 USC Section 1396a (10)." The use of this language would have limited Section 1396a (f) to Supplemental Security Income recipients.

Therefore, the District Court erred in its conclusion, stated in its Memorandum and Order of July 9, 1975, that "the aforesaid 1396a (10) (A) requires States such as Missouri participating in Federal State Medical Assistance programs to provide Medical Assistance coverage to all recipients of SSI."

The Regulations promulgated under 42 USC Section 1396a underscore the Congressional intent that States are to be allowed latitude in determining eligibility for Medical Assistance. Specifically, the regulations provide that the State, at its option, can restrict eligibility for Medical Assistance. 39 FR 9512, March 11, 1974 states:

> "Congressional intent . . . was clearly to allow States to restrict coverage, not to provide them an option to broaden it. . ."

45 CFR Section 248.1 specifically refers to the State's option "to limit Medicaid coverage of aged, blind and disabled individuals."

The correctness of Petitioners' contentions is evident considering the fact that welfare, as stated by this Court on several occasions, is a scheme of cooperative federalism. *King* v. *Smith, supra*; *Dandridge* v. *Williams, supra*; *Jefferson* v. *Hackney, supra,* and *New York State Department of Social Services* v. *Dublino, supra.* States are not required to participate in federal welfare programs but if they desire to take advantage of the substantial federal funds available they must meet the requirements specified in the federal statutes and regulations. Missouri voluntarily decided to participate in the former federally matched programs of OAA, AB and PTD. Missouri, thereby, subjected itself to the federal requirements as to the persons included in the Medicaid Program. However, at no time did the State of Missouri consent or agree to subject itself to federal regulation of the persons to be covered by the General Relief program and the medical assistance benefits available to them. This is clearly in line with the principle of cooperative federalism, that Federal requirements apply only to federally funded programs. This is a principle which the Congress of the United States established and has continuously recognized in the area of public assistance benefits. To hold as the Courts below did that Congress intended to exercise control over a classification of persons not previously covered by federal statutes or federal regulations is to ignore a basic tenet of public assistance in the United States.

If the decision of the Court of Appeals is allowed to stand a federal court in effect will have told the State of Missouri what benefits it must pay from its own funds as an incident to eligibility from exclusively state-funded cash assistance programs. Manifestly, this is a state question for state determination. The decision of the Court of Appeals has taken cooperative out of cooperative federalism.

2.

The Court of Appeals in interpreting 42 USC 1396a has failed to consider the interpretation given this statute by the officers and agency charged with its administration.

The decision of the Court of Appeals is in conflict with decisions of this Court in *Udall* v. *Tallman*, 380 U.S. 1 (1965), and *Lewis* v. *Martin*, 397 U.S. 552 (1970) in that the Court below has failed to consider the interpretation given the statutes involved by the officers and agency charged with its administration.

Missouri's medical assistance plan, as currently in effect, was submitted to the Secretary of Health, Education and Welfare for his approval. 42 USC Section 1396a (b). The Missouri State Plan has been approved by the Secretary of HEW, and therefore, is considered by HEW to be in conformity with the statutes and regulations of HEW.

The courts below held that 42 USC 1396a (10) (A) requires the states to provide medical assistance to all recipients of the federal SSI benefits. The Court further stated that 42 USC 1396a (f) provides an exception to the general coverage of SSI benefits and allows the states to limit coverage based on January 1, 1972 eligibility requirements.

It has been the contention of the Petitioners that in fact 1396a (f) does not provide an exception to Section 1396a (10) (A) but is an alternative to that section. The States, as an alternative to providing benefits to all SSI recipients, may provide as medical assistance to all individuals who meet the former eligibility requirements for the federally matched programs of OAA, AB and PTD.

With the implementation of the SSI program new eligibility criteria were established on a nationwide basis

for aged, blind and disabled individuals. Prior to this time the states had been allowed to establish their own and different eligibility criteria within the general framework as prescribed in the Social Security Act. With the implementation of nationwide standards many thousands of additional people became newly eligible for assistance as aged, blind or disabled. In recognizing that these numbers of newly eligible persons could cause serious financial consequences to the states, Congress intended to leave the decision as to whether to cover these newly eligible persons to each individual state. Committee on Ways and Means, Report on H.R. 1, H.R. Rep. No. 92-231, 92nd Cong., 1st Ses. 197 (1971). To allow the states the option not to expand their financial liability but also to insure that the states could not limit their liability the Congress through Section 1396a (f) provided the states the alternative to continue to cover those aged, blind and disabled persons required to cover by federal statutes on January 1, 1972.

This is the interpretation the Secretary of HEW placed upon this state, and implemented this interpretation through HEW regulations. 45 CFR Section 248.1 (b):

> "(2) In the case of the aged, blind and disabled, include one of the groups listed in paragraph (b) (2) (i), or (III) of this section, and in addition, those listed in paragraph (b) (2) (iv), (v) and (vi) of this section:
>
> (i) Individuals receiving a benefit under title XVI (for purposes of the regulations in this part, the phrase "individuals receiving a benefit under title XVI" includes the eligible spouses of such individuals), or
>
> (ii) Individuals receiving a benefit under title XVI or a State supplementary payment which meets the conditions specified in Section 248.2 (d), or

(iii) Individuals who meet the eligibility criteria used for medical assistance on January 1, 1972 (or any other criteria which are less restrictive than the January 1, 1972 criteria but no less restrictive than the comparable criteria under title XVI or for a State supplementary payment which meets standards described in Section 248.2(d)), after the amount of the title XVI payment and State supplementary payment (*if any*) and incurred medical expenses are deducted from income;"

This regulation provides for three categories of individuals and the states are required to cover at least one of these classifications. Subparagraph (i) provides for the coverage of all SSI recipients; subparagraph (ii) provides for the coverage of all SSI recipients and all recipients of state supplemental payment; and subparagraph (iii) provides for the coverage of all persons who meet the January 1, 1972 criteria for aged, blind or disabled. It is the option provided in subparagraph (iii) which was chosen by the State of Missouri.

The Regulations contained in 45 CFR 248.1 clearly do not limit the medical assistance program to recipients of SSI only. Throughout this regulation the term "if any" is used in relation to SSI payments as when the regulation covers the option provided under (iii). It is, therefore, clear that HEW does not limit coverage to SSI recipients and provides for the option as instituted by the State of Missouri. Further, the regulations do not provide for the program that the Court below now requires the State of Missouri to implement, that is to cover all SSI recipients who meet the former eligibility requirements in effect in January 1972.

The State of Missouri exercised its option under the Statutes and Regulations to cover through its Medical Assistance Program only those eligible under the January 1, 1972 criteria for aged, blind and disabled. GR eligible persons did not in January 1, 1972, and do not today meet these criteria for aged, blind, and disabled. In fact, the criteria for GR eligibility is less restrictive than the criteria for eligibility under Title XVI, and therefore, the State cannot include all GR eligible persons under its program for Medical Assistance under the above 45 CFR 248.1 (b)(2)(iii). The State of Missouri could have included in its Medical Assistance program plaintiff and the class she represents by using less restrictive criteria than its January 1, 1972 criteria. However, the State of Missouri exercised the option not to extend its coverage beyond that of January 1, 1972. To include persons eligible for GR under the January 1, 1972 criteria would be to expand the Medical Assistance program beyond the coverage allowable by the Federal regulations and statutes.

While the class to which plaintiff belongs could have been included in the State's present Medical Assistance plan, at the option of the State, it was not. Thus, the State of Missouri in its State plan has retained its January 1, 1972 definitions of aged, blindness and disability. Only persons meeting these definitions can qualify for Medical Assistance unless they are eligible under another assistance program. GR eligible persons could not meet these definitions and were only covered by Medical Assistance because the State of Missouri has exercised its option to cover them through its own program of Medical Assistance which is totally state-funded and administered. The plaintiff through her action is trying to impose upon the State of Missouri mandatory coverage where, in fact, this plaintiff and her class can only be covered if the State of

Missouri exercises its option to do so. (Specifically, Missouri is continuing to provide Medical Assistance to those persons to whom it was required to provide such assistance on January 1, 1972, under Title XIX: specifically, those persons formerly eligible for OAA, AB and PTD.)

Because the Courts below have totally disregarded the interpretation of this statute by HEW and the regulations promulgated by HEW a very serious question of major federal importance has arisen. The decisions below have in reality held that the regulations of HEW are contrary to the Social Security Act. The result being that every medical assistance program in every state of this nation is subject to being held contrary to the Social Security Act. There are eleven states which cover those persons eligible under January 1972 eligibility differently, and the remainder of the states provide coverage to all recipients of SSI. 2 CCH Medicare and Medicaid Guide, Paragraph 15,501 et seq. (1974).

As all the states have relied on the HEW regulations in designing their Medicaid programs, if the decision of the Court of Appeals is allowed to stand without review by the Court, all 50 states will find their programs in jeopardy. Further, this would also subject many current recipients of medical assistance including recipients and non-recipients of SSI to the distinct possibility of losing their eligibility for medical asssistance. Because of the serious implications of a decision in this area of public assistance, a definite and final resolution by the Court is necessary before the occurrence of irreparable and unconscionable consequences.

II

The Order of the District Court wherein it required that notice be sent to the class represented by Appellant that they may now be eligible for assistance is barred by the 11th Amendment to the United States Constitution.

The District Court ordered the defendants to notify by first-class mail all persons who had been denied Medical Assistance by defendants for failure to meet Missouri's January 1, 1972, OAA, AB, and PTD eligibility criteria of their possible eligibility for Medical Assistance based on GR criteria. The practical effect of this part of the court's order is to require the State to expend substantial amounts of public funds to comply with this notice requirement. The District Court has, therefore, imposed a financial liability to private persons to be paid by public funds. The imposition is barred by the Eleventh Amendment. *Edelman* v. *Jordon*, 416 U.S. 1000 (1974).

The monetary loss which resulted from a past breach of legal duty is clearly prohibited by the Eleventh Amendment. In *Edelman* v. *Jordon*, the Court stated:

> "But that portion of the District Court's decree which petitioners challenge on Eleventh Amendment grounds goes much further than any of the cases cited. It requires payment of state funds, not as a necessary consequence of compliance in the future with a substantive federal question determination, but as a form of compensation to those whose applications were processed on the slower time schedule at a time when petitioners were under no court-imposed obligation to conform to a different standard. While the Court of Appeals described this retroactive award of mone-

tary relief as a form of 'equitable restitution', it is in practical effect indistinguishable in many aspects from an award of damages against the State. It will to a virtual certainty be paid from state funds, and not from the pocket of the individual state official who was the defendant in the action. It is measured in terms of a monetary loss resulting from a past breach of a legal duty on the part of the defendant state officials."

Therefore, the Order of the Court of Appeals wherein it held that the notice be sent is in direct conflict with prior decisions of this Court.

CONCLUSION

For the foregoing reasons, Petitioners pray this Writ of Certiorari be granted.

Respectfully submitted,

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APPENDIX

APPENDIX A

IN THE UNITED STATES DISTRICT COURT FOR THE
EASTERN DISTRICT OF MISSOURI
EASTERN DIVISION

No. 74-380 C (3)

HARIECE LEWIS, ET AL.,
Plaintiff,

vs.

BERT SHULIMSON, ET AL.,
Defendants.

July 9, 1975

MEMORANDUM AND ORDER

This class action seeks injunctive and declaratory relief pursuant to 42 U.S.C. § 1983, and 28 U.S.C. § 2201, et seq. This Court has jurisdiction over the parties pursuant to 28 U.S.C. § 1343. The parties have agreed that this matter may be tried upon stipulated facts and the briefs of opposing counsel.

The plaintiff, representative of the class of recipients of federal Supplemental Security Income (hereinafter SSI) benefits, seeks to have defendants enjoined from further denying medical assistance under State regulations promulgated and enforced by the defendants. The lawsuit in-

volves issues of statutory construction of amendments to Title XIX of the federal Social Security Act, 42 U.S.C. § 1396, et seq., and certain regulations promulgated thereunder, which provide for medical assistance coverage for certain recipients of the newly implemented SSI program, and which set forth the eligibility requirements for medical assistance which must be followed by states, such as Missouri, which participate in federal-state medical assistance programs.

The plaintiff, Hariece Lewis, is a resident of St. Louis, Missouri, and maintains a household for herself and her daughter. Mrs. Lewis suffers from diabetes and other medical disabilities, and has been unemployed for several years. As a direct result of these medical disabilities, the plaintiff incurs medical expenses of approximately $60.00 per month. At the present time, Mrs. Lewis' only source of income for her and her household are SSI disability benefits of $72.00 per month, Social Security disability benefits of $87.00 per month, for herself, and Social Security benefits of $46.00 per month, for her daughter.

In December of 1973, Mrs. Lewis applied for SSI disability benefits through the federal Social Security Administration. That Administration found her eligible for such disability benefits, and she started receiving monthly SSI payments in March of 1974. The plaintiff is presently receiving the monthly SSI benefits.

The determination that a person is needy and disabled, and is therefore eligible to receive SSI benefits, does not automatically entitle one to medical assistance coverage from the defendants. Therefore, in February, 1974, Mrs. Lewis applied for medical assistance at the St. Louis City Welfare Office of the Missouri Division of Family Services. At that time, Mrs. Lewis was informed by a caseworker at the St. Louis City Welfare Office that she was ineligible

for medical assistance under the Division's State Regulation No. 138, and Division Policy Memorandum PA-713 which govern eligibility of SSI recipients for medical assistance coverage. Under the aforementioned Division Regulation and Policy Memorandum, only those SSI recipients who meet the January 1, 1972, Missouri Old-Age Assistance (OAA), Aid to the Blind (AB), or Aid to the Permanently and Totally Disabled (PTD) eligibility requirements, are eligible for medical assistance coverage. Those SSI recipients who only meet the January 1, 1972, Missouri General Relief (GR) eligibility requirements are not eligible for medical assistance coverage.

It was determined by the Division that, prior to her application for medical assistance, Mrs. Lewis would have been eligible for General Relief benefits under the Division's General Relief eligibility requirements in effect in Missouri on January 1, 1972. It was also determined that she would not be eligible for OAA, AB or PTD under the Division's eligibility requirements for those programs in effect in Missouri on January 1, 1972.

At the present time, and on January 1, 1972, under § 208.151, R.S. Mo., 1969, any persons receiving General Relief benefits in Missouri is eligible for medical assistance coverage. However, although Mrs. Lewis could presently qualify for state General Relief benefits, she cannot obtain General Relief and thereby obtain medical assistance because she is eligible for and receiving federal SSI benefits. Under present Missouri law, §§ 208.015 and 208.030, R.S. Mo., 1973, as implemented by Division Policy Memorandum PA-711, any person now applying for State General Relief is required to first apply for SSI benefits. If such a person is found eligible for SSI benefits, he or she cannot receive State General Relief benefits.

The legal question before the Court is whether or not the enabling legislation of the SSI benefits, 42 U.S.C. § 1396(a)10 and § 1396(a)(f), and regulations promulgated thereunder, 45 C.F.R. § 248.1(b)(2)(iii), require defendants to provide medical assistance to members of the plaintiff's class.

It is clear that under the Social Security laws that any state eligibility standard that excludes persons eligible for assistance under the federal medical assistance eligibility standards of Title XIX violates the federal Social Security Act and is therefore invalid under the Supremacy Clause of the United States Constitution, unless the state exclusion is clearly authorized by the language of the Act or its legislative history. *Townsend* v. *Swank*, 404 U.S. 282 (1971); and *Carleson* v. *Remillard*, 406 U.S. 598 (1972). Once a federal standard of eligibility is defined by the Act, aid may not be denied by a participating state to persons who come within the federal statutory eligibility requirements, unless there is a clear indication that Congress meant the coverage to be optional. *Burns* v. *Alcala*, ... U.S. ....., 95 Sup. Ct. 1180 (1975).

The aforecited § 1396(a)(10)(A) requires states, such as Missouri, participating in federal-state medical assistance programs to provide medical assistance coverage to all recipients of SSI. § 1396(a)(f) has a limited exception to the above rule by stating which SSI recipients the states are not required to extend medical assistance coverage to, providing in pertinent part:

> "Notwithstanding any other provision of this subchapter . . . no state . . . shall be required to provide medical assistance to any aged, blind or disabled individual (within the meaning of subchapter XVI of this Chapter) for any month unless such state would be or

> would have been) required to provide medical assistance to such individual for such month had its plan, for medical assistance approved under this Chapter and in effect on January 1, 1972, been in effect in such month . . ."

Subchapter XVI is the title of the Social Security Act which establishes the federal SSI program, 42 U.S.C. § 1381, et seq.

It is this Court's opinion that the aforecited language of § 1396(a)(f) permits the State of Missouri to exclude individuals from medical assistance coverage unless the State of Missouri would have been required to provide medical assistance to such persons under Missouri's medical assistance plan in effect on January 1, 1972. It is clear that under Missouri's January 1, 1972, approved medical assistance plan, the defendants were required to provide medical assistance to all recipients of OAA, AB, PTD, ADC and General Relief. The medical assistance coverage of individuals who are receiving General Relief is required by §208.151 R.S.Mo., 1969, the Missouri medical assistance statute in effect on January 1, 1972. Such a construction of the applicable federal statutes has been upheld by the United States District Court for the Northern District of Mississippi in *West* v. *Cole*, 390 F. Supp. 91 (1975).

Thus, it becomes clear that using the normal rules of statutory construction that plaintiff and the members of the class which she represents are entitled to the injunctive and declaratory relief which they seek. In consequence,

IT IS HEREBY ORDERED that plaintiff's prayer for declaratory and injunctive relief be and is GRANTED; and

IT IS FURTHER ORDERED that plaintiff's counsel shall prepare the appropriate orders to implement the relief prayed for; and

IT IS FURTHER ORDERED that defendant shall pay costs.

Dated this 9th day of July, 1975.

/s/ H. Kenneth Wangelin
H. Kenneth Wangelin
United States District Judge

IN THE UNITED STATES DISTRICT COURT FOR
THE EASTERN DISTRICT OF MISSOURI
EASTERN DIVISION

Civil No. 74-380C (3)

HARIECE LEWIS, et al.,
Plaintiff,
vs.
BERT SHULIMSON, et al.,
Defendants.

July 22, 1975

ORDER

The Memorandum and Order of this Court entered in the above-entitled case on July 9, 1975 is hereby incorporated in and made a part of this order.

IT IS HEREBY ORDERED, ADJUDGED, AND DECREED, pursuant to 28 U.S.C. §2201 and §2202, that Title XIX of the Social Security Act, specifically, 42 U.S.C. §§1396a(a)(10)(A) and (f), and federal regulations promulgated thereunder, 45 CFR §248.1(b)(2)(iii), require the Missouri Division of Welfare (now called the Division of Family Services) to provide medical assistance to those recipients of SSI benefits in Missouri who meet the January 1, 1972 Missouri General Relief eligibility requirements as well as to those who meet the January 1, 1972 Missouri OAA, AB, PTD, or ADC eligibility requirements. And therefore, Missouri Division of Welfare Regulation No. 138 and Policy Memorandum PA-713, and defendants' denial of medical assistance to plaintiff and the members of the

class she represents pursuant to said regulation and policy, are in violation of 42 U.S.C. §§1396a(a)(10)(A) and (f), and 45 CFR §248.1(b)(2)(iii), and are therefore invalid under the Supremacy Clause of the United States Constitution, in that said regulation and policy deny medical assistance to those SSI recipients in Missouri, such as plaintiff and the members of her class, who only meet the General Relief eligibility requirements in effect in Missouri on January 1, 1972.

IT IS FURTHER ORDERED, ADJUDGED, AND DECREED that the defendants, their successors in office, agents, and employees, and all other persons in active concert and participation with them, are permanently enjoined from denying medical assistance coverage to plaintiff and the members of the class she represents, or any other SSI recipients in Missouri, on the grounds that they only meet the General Relief eligibility requirements in effect in Missouri on January 1, 1972, but do not meet the OAA, AB, or PTD eligibility requirements in effect in Missouri on January 1, 1972.

IT IS FURTHER ORDERED that the defendants, their successors in office, agents and employees, shall notify promptly by first class mail at their last known address all persons receiving SSI benefits in Missouri who have been denied medical assistance because they do not meet the January 1, 1972 Missouri OAA, AB, or PTD eligibility requirements, but who may meet the January 1, 1972 Missouri General Relief eligibility requirements, that they may now be eligible for medical assistance and may reapply for such benefits.

Dated this 22nd day of July, 1975.

/s/ H. Kenneth Wangelin
H. Kenneth Wangelin
United States District Judge

APPENDIX B

UNITED STATES COURT OF APPEALS
FOR THE EIGHTH CIRCUIT

No. 75-1735

Hariece Lewis, etc.,
Appellee,

v.

Bert Shulimson, et al.,
Appellants.

Appeal From the United States District Court
for the Eastern District of Missouri.

Submitted: March 11, 1976
Filed: April 20, 1976

Before VOGEL and VAN OOSTERHOUT, Senior Circuit Judges, and BRIGHT, Circuit Judge.

VOGEL, Senior Circuit Judge.

This is an appeal by the Division of Family Services (formerly the Divison of Welfare) of the State of Missouri from a determination by the District Court, Hon. H. Kenneth Wangelin presiding, that where under Missouri's January 1, 1972, medical assistance plan the state was required by § 208.151, R.S.Mo. 1969, to provide medical assistance to persons eligible for general relief, and appellee and

members of her class presently qualify under the January 1, 1972, Missouri general relief eligibility requirements, 42 U.S.C. § 1396a(a)(10)(A) and § 1396a (f) require appellants to provide medical assistance to members of appellee's class.

Appellant also alleges that the District Court, in ordering appellants to promptly notify all members of appellee's class who were denied medical assistance in violation of the District Court order, thereby required the State of Missouri to expend its public funds to satisfy a liability to private parties, in violation of the Eleventh Amendment. The District Court did not, however, require Missouri to make any retroactive payments to appellee and members of her class. It is clear that the type of notification expenses involved here are the necessary result of compliance with a decree which by its terms is prospective in nature. Such "ancillary effect" on the state treasury is permissible under *Edelman* v. *Jordan,* 415 U.S. 651, 39 L.Ed.2d 662, 94 S.Ct. 1347.

After a careful review of the record, briefs and arguments of counsel, the court affirms the judgment of the District Court on the basis of its Memorandum Opinion and our comments above. *Lewis* v. *Shulimson,* 400 F. Supp. 807 (E.D. Mo. July 9, 1975).

Affirmed.

A true copy.

Attest:

Clerk, U.S. Court of Appeals, Eighth Circuit

UNITED STATES COURT OF APPEALS
FOR THE EIGHTH CIRCUIT

September Term, 1975
75-1735

Hariece Lewis, etc.,
Appellee,

vs.

Bert Shulimson etc., et al.,
Appellants.

Appeal From the United States District Court
for the Eastern District of Missouri

The Court having considered petition for rehearing en banc filed by counsel for appellants and, being fully advised in the premises, it is ordered that the petition for rehearing en banc be, and is hereby, denied.

Considering the petition for rehearing en banc as a petition for rehearing, it is ordered that the petition for rehearing also be, and it is hereby denied.

May 13, 1976

APPENDIX C

42 U.S. Code Section 1396 provides:

(a) A State plan for medical assistance must—. . .
(10) provide—

(A) for making medical assistance available to all individuals receiving aid or assistance under any plan of the State approved under title I, X, XIV, or XVI, or part A of title IV, or with respect to whom supplemental security income benefits are being paid under title XVI; . . .

(f) Notwithstanding any other provisions of this title, except as provided in subsection (e), no State not eligible to participate in the State plan program established under title XVI shall be required to provide medical assistance to any aged, blind, or disabled individual (within the meaning of title XVI) for any month unless such State would be (or would have been) required to provide medical assistance to such individual for such month had its plan for medical assistance approved under this title and in effect on January 1, 1972, been in effect in such month, except that for this purpose any such individual shall be deemed eligible for medical assistance under such State plan if (in addition to meeting such other requirements as are or may be imposed under the State plan) the income of any such individual as determined in accordance with section 1903 (f) (after deducting any supplemental security income payment and State supplementary payment made with respect to such individual and incurred expenses for medical care as recognized under State law) is not in excess of the standard for medical assistance established under the State plan as in

effect on January 1, 1972. In States which provide medical assistance to individuals pursuant to clause (10) (C) of subsection (a) of this section, an individual who is eligible for medical assistance by reason of the requirements of this section concerning the deduction of incurred medical expenses from income shall be considered an individual eligible for medical assistance under clause (10) (A) of that subsection if that individual is, or is eligible to be (1) an individual with respect to whom there is payable a State supplementary payment on the basis of which similarly situated individuals are eligible to receive medical assistance equal in amount, duration, and scope to that provided to individuals eligible under clause (10) (A), or (2) an eligible individual or eligible spouse, as defined in title XVI, with respect to whom supplemental security income benefits are payable; otherwise that individual shall be considered to be an individual eligible for medical assistance under clause (10) (C) of that subsection. In States which do not provide medical assistance to individuals pursuant to clause (10) (C) of that subsection, an individual who is eligible for medical assistance by reason of the requirements of this section concerning the deduction of incurred medical expenses from income shall be considered an individual eligible for medical assistance under clause (10) (A) of that subsection.

45 CFR 248.1 provides:

(B) In a State which covers only the categorically needy under its title XIX plan, and in addition has exercised its option under section 209(b) of Pub. L. 92-603 to limit Medicaid coverage of aged, blind, and disabled individuals, all individuals establishing eligibility for medical assistance by deducting their title

XVI payments (if any) and incurred medical expenses from income will be considered categorically needy regardless of whether their income would allow them to qualify for cash assistance." . . .

(b) *Required coverage of the categorically needy.* A State plan under title XIX of the Social Security Act must specify what groups of individuals are covered as categorically needy for Medicaid. These groups must as a minimum—(1) In the case of families and children, include: (i) All individuals receiving aid under the State's approved plan under title IV-A;

. . . (2) In the case of the aged, blind and disabled, include one of the groups listed in paragraph (b)(2)(i) (ii) or (iii) of this section, and in addition, those listed in paragraph (b)(2)(iv), (v) and (vi) of this section:

(i) Individuals receiving a benefit under title XVI (for purposes of the regulations in this part, the phrase "individuals receiving a benefit under title XVI" includes the eligible spouses of such individuals), or

(ii) Individuals receiving a benefit under title XVI or a State supplementary payment which meets the conditions specified in Section 248.2(d), or

(iii) Individuals who meet the eligibility criteria used for medical assistance on January 1, 1972 (or any other criteria which are less restrictive than the January 1, 1972 criteria but no less restrictive than the comparable criteria under title XVI or for a State supplementary payment which meets standards described in Section 248.2(d)), after the amount of the title XVI payment and State supplementary payment (if any) and incurred medical expenses are deducted from income.

No. 76-188

In the Supreme Court of the United States

OCTOBER TERM, 1976

ERVING B. GOURLEY, DIRECTOR OF THE DIVISION OF FAMILY SERVICES OF THE STATE OF MISSOURI, ET AL.,
PETITIONERS

v.

HARIECE LEWIS, ET AL.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE EIGHTH CIRCUIT

MEMORANDUM FOR THE UNITED STATES AS AMICUS CURIAE

DANIEL M. FRIEDMAN,
Acting Solicitor General,
Department of Justice,
Washington, D.C. 20530.

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ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE EIGHTH CIRCUIT

MEMORANDUM FOR THE UNITED STATES AS AMICUS CURIAE

This submission is made in response to the Court's invitation to the Solicitor General to express the views of the United States.

QUESTION PRESENTED

The United States will address the following question: Whether a state that participates in the medicaid program is required to provide federally assisted medical aid to supplemental security income recipients to whom it would have been required to provide exclusively state-financed medical aid had its 1972 medicaid plan remained in effect.

STATUTORY PROVISIONS INVOLVED

Section 1902 of the Social Security Act, as added, 79 Stat. 334, and amended, 42 U.S.C. (Supp. V) 1396a, provides in pertinent part:

(a) A State plan for medical assistance must—

* * * * *

(10) provide—

(A) for making medical assistance available all individuals receiving aid or assistance under any plan of the State approved under title I, X, XIV, or XVI, or part A of title IV of this Act, or with respect to whom supplemental security income benefits are being paid under title XVI of this Act;

* * * and

(C) if medical assistance is included for any group of individuals who are not described in clause (A) and who do not meet the income and resources requirements of the appropriate State plan, or the supplemental security income program under title XVI of this Act, as the case may be, as determined in accordance with standards prescribed by the Secretary—

(i) for making medical assistance available to all individuals who would, except for income and resources, be eligible for aid or assistance under any such State plan or to have paid with respect to them supplemental security income benefits under title XVI of this Act, and who have insufficient (as determined in accordance with comparable standards) income and resources to meet the costs of necessary medical and remedial care and services * * *.

* * * * *

(f) Nothwithstanding any other provision of this title, * * * no State * * * shall be required to provide medical assistance to any aged, blind, or disabled individual (within the meaning of title XVI of this Act) for any month unless such State would be (or would have been) required to provide medical assistance to such individual for such month had its plan for medical assistance approved under this title and in effect on January 1, 1972, been in effect in such month * * *.

STATEMENT

1. Title XIX of the Social Security Act, as added, 79 Stat. 343, and amended, 42 U.S.C. (and Supp. V) 1396 *et seq.*, creates a cooperative federal-state program, commonly called "medicaid," for the payment of the medical expenses of certain categories of needy individuals. In order to participate in the medicaid program, a state must establish a medicaid plan and submit it to the Secretary of Health, Education, and Welfare for approval.

a. Prior to 1974, to be approved a state medicaid plan was required, at a minimum, to cover "individuals receiving aid or assistance under State plans approved under titles I, X, XIV, and XVI of this Act [relating to old-age assistance, aid to the blind, aid to the permanently and totally disabled, and aid to the aged, blind, or disabled], and part A of title IV of this Act [relating to aid to families with dependent children]." Section 1902(a)(10) of the Act, 42 U.S.C. (1970 ed.) 1396a(a)(10). These individuals are generally referred to as the "categorically needy." In addition, the state plan, at the state's option, also could cover individuals who satisfied the physical requisites (*e.g.*, age, blindness, or disability) but not the means test for categorical assistance, but whose income and resources nevertheless were insufficient to meet the costs of necessary medical or remedial care or services.

Sections 1902(a)(10) and 1905(a) of the Act, 42 U.S.C. (1970 ed.) 1396a(a)(10) and 1396d(a). These individuals are generally referred to as the "medically needy."

Once a state's plan was approved by the Secretary, the federal government paid to the state a specified percentage of the medical expenses that had been paid by the state on behalf of the categorically needy and, if covered by the plan, the medically needy. Section 1903(a) of the Act, 42 U.S.C. (1970 ed.) 1396b(a). Although a state's plan might also have covered individuals who were neither categorically nor medically needy, the federal government did not reimburse the states for payments made to such individuals. *Ibid.*

b. In 1974, the statutory structure of federal-state assistance to the categorically needy was significantly amended. Titles I, X, and XIV of the Social Security Act were repealed (except with respect to Puerto Rico, Guam, and the Virgin Islands). See Section 303 of Pub. L. 92-603, 86 Stat. 1484. To replace the programs that had existed under those Titles, Title XVI was amended to establish a program of supplemental security income for the aged, blind, and disabled. Title XVI of the Act, 86 Stat. 1465, 42 U.S.C. (Supp. V) 1381 *et seq.*

To reflect this change, Congress also amended Section 1902(a)(10) of the Act to require states participating in the Title XIX medicaid program to furnish medical assistance "to all individuals * * * with respect to whom supplemental security income benefits are being paid under title XVI."[1] Congress also recognized, however, that more

[1]Since the program of aid to families with dependent children (Title IV-A) had not been affected by the new amendments, and the categorical assistance programs under Titles I, X, and XIV, and old Title XVI, had not been repealed or amended with respect to certain territories, Section 1902(a)(10) retains the requirement that medical aid be furnished to individuals receiving assistance under those programs.

individuals would be eligible under the supplemental security income program than had been eligible under the superseded categorical assistance programs, *i.e.*, that the new legislation had resulted in an expansion of the class of individuals considered to be categorically needy, and that it might be financially burdensome to the states to be forced similarly to expand medicaid coverage. See S. Rep. No. 93-553, 93d Cong., 1st Sess. 56 (1973). Congress therefore added Section 1902(f) of the Act, providing that "[n]otwithstanding any other provision of this title, * * * no State * * * shall be required to provide medical assistance to any aged, blind, or disabled individual (within the meaning of title XVI * * *) * * * unless such State * * * would have been * * * required to provide medical assistance to such individual for such month had its plan for medical assistance approved under this title and in effect on January 1, 1972, been in effect * * * ." 42 U.S.C. (Supp. V) 1396a(f).

In pertinent part, the medicaid program otherwise remained as it had been before 1974.

2. In 1972, the medicaid plan of the State of Missouri covered the categorically needy, as it was required to do as a condition of approval, and the federal government paid a portion of the costs incurred by the State in providing medical aid to those individuals.[2] The State's plan did not cover the medically needy but the State did provide medical aid to individuals, other than the categorically needy, who received welfare assistance under the State's own general relief program (Add. Stip. 2). Although the latter coverage

[2]The State at that time participated in the categorical assistance programs of Titles I, IV-A, X, and XIV; it did not participate in the old Title XVI program (Add. Stip. 2). "Stip." and "Add. Stip." refer to the stipulation and additional stipulation of facts filed by the parties in the district court.

was provided under the state plan approved by the Secretary, the federal government did not reimburse the State for its medical payments to or on behalf of those individuals (Add. Stip. 2), because such coverage was outside the scope of Title XIX. The State was entitled, however, to federal reimbursement of 50 percent of the plan's administrative expenses, including the expenses of administering the exclusively state-financed portion of the plan's coverage. See Section 1903(a)(3) of the Act, 42 U.S.C. (1970 ed.) 1396b(a)(3).

The State amended the federally assisted portion of its plan in 1974 following the amendments to the federal statute. Pursuant to Section 1902(f), the State determined not to extend medicaid coverage to individuals eligible for supplemental security income benefits who would not have been eligible for benefits under the superseded categorical assistance programs (Stip. 4; Add. Stip. 2). The Secretary approved the new plan (Add. Stip. 1-2).

3. Respondent Lewis receives supplemental security income but would not have been eligible for benefits under the superseded categorical assistance programs (Stip. 4). She therefore is not eligible for federally funded medical assistance under the State's amended plan (*ibid.*).

Nor is respondent eligible for medical aid under the state-financed portion of the State's plan. That portion of the plan provides medical aid only to individuals receiving welfare assistance under the State's general relief program, and because respondent now receives supplemental security income she no longer is eligible, as she would have been in 1972, to receive state welfare assistance (Pet. App. A3). Accordingly, when respondent applied to the State for medical aid, her application was denied.

Respondent then commenced this action in the United States District Court for the Eastern District of Missouri, on behalf of herself and others similarly situated,

challenging the exclusion of such individuals from coverage under the State's medicaid plan. She contended, *inter alia*, that since she would have qualified for medical aid under the State's general relief program in the absence of the enactment of the supplemental security income program, the State was required to provide her with medical assistance under Title XIX.

The district court entered judgment for respondent (Pet. App. A7-A8). The court construed Section 1902(f) of the Act as permitting the State of Missouri "to exclude individuals from medical assistance coverage unless the State * * * would have been * * * required to provide medical assistance to such persons under Missouri's medical assistance plan in effect on January 1, 1972" (Pet. App. A5). The court found that "under Missouri's January 1, 1972, approved medical assistance plan, the [State was] required to provide medical assistance to all recipients of * * * General Relief" *(ibid.)*. Accordingly, the district court ordered petitioners "to provide medical assistance to those recipients of [supplemental security income] benefits in Missouri who meet the January 1, 1972 Missouri General Relief eligibility requirements * * * " (*id.* at A7-A8). The court of appeals affirmed (*id.* at A9-A10; see *id.* at A11).

DISCUSSION

The State of Missouri is not required by Title XIX of the Social Security Act to provide medical aid to respondent and the class she represents "unless [the] State * * * would have been * * * required to provide medical assistance to such individual[s] * * * had its plan for medical assistance approved under [Title XIX] and in effect on January 1, 1972, been in effect * * * ." Section 1902(f) of the Act. The courts below determined that this statutory provision did not permit the State to exclude respondents from medicaid coverage because in 1972 the State had provided medical aid to similarly situated individuals as part of its program of general relief. We do not believe that Congress intended this result.

This case turns, at least in part, on considerations of federalism. Under the lower courts' reading of Section 1902(f), because a state conducted its own state-financed medical aid program in the past, it now must provide medicaid to individuals whom it otherwise would be entitled to exclude from coverage. In other words, the courts below concluded that Congress, in amending Title XIX, differentiated between the states on the basis of whether they had conducted their own state-financed medical aid programs in 1972, and that it chose to impose a heavier burden on the states that had conducted such programs. But if Congress had intended to disadvantage states for having conducted, with their own monies, welfare programs more expansive than those the federal government had theretofore been willing to sponsor, surely that intention would have stimulated debate and controversy. The courts below point to no such debate, and we have found none.

In the absence of compelling legislative history to the contrary, it should be presumed that Congress was not concerned with the scope of state-financed relief programs and did not intend either to interfere with a state's ability to expand or contract such a program or to impose some special burden upon a state because of the operation of such a program in the past.[3] Congress can fairly be understood to have been concerned, in enacting Section 1902(f), only with the relationship of the new supplemental security income program to the existing federal-state medicaid programs.

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[3]The State of Missouri was entitled to receive, and presumably did receive, federal assistance to cover a portion of the purely administrative costs of operating its program of exclusively state-financed payments to general relief recipients. See Section 1903(a) (3) of the Act. But we are not aware of anything in the legislative history that indicates that Congress intended that such a limited federal nexus be the basis for imposing greater medicaid burdens upon the states.

Viewed from this perspective, Section 1902(f) can be seen as standing, at a minimum, for the proposition that the states are not required to expand the scope of their pre-1974 federally funded medicaid programs as a result of the enactment of the supplemental security income program. That proposition is fully consistent with the State's refusal to extend medicaid coverage to the respondent class. Moreover, as we now show, the language of Section 1902(f) conforms with this understanding of its purpose and meaning.

1. The decisions below rest upon the legal conclusion that, within the meaning of Section 1902(f), the State "would have been * * * required to provide medical assistance to" respondents under its 1972 medical plan (see Pet. App. A5). That conclusion was based upon a misunderstanding of the term "medical assistance."

As has been indicated, the medical aid provided to the respondent class under the 1972 plan was made available under a wholly state-financed general relief program; no federal funds were claimed or received by the State for payments made with respect to the respondent class (*ibid.*). But under the Act, "medical assistance" refers solely to medical aid that qualifies for federal matching funds. "[T]he Secretary * * * shall pay to each State which has a plan approved under this title * * * an amount equal to [a specified] percentage * * * of the total amount expended * * * *as medical assistance* under the State plan * * *." Section 1903(a)(1) of the Act, 42 U.S.C. (Supp. V) 1396b(a)(1) (emphasis added). See also Section 1902(a)(10) of the Act. In turn, "medical assistance" is defined as payments to certain individuals—the categorically or medically needy—for certain medical

services or needs. Section 1905 (a) of the Act.[4] Payments to other individuals, or for other medical services or needs, are not "medical assistance" and do not qualify for federal matching.

In other words, if payments qualify for federal reimbursement, they constitute "medical assistance"; otherwise, they do not. It is stipulated that in 1972 medical aid to the respondent class did not qualify for federal reimbursement. The necessary legal inference, therefore, is that that medical aid was not "medical assistance" as that term is used in the Act.[5] In short, the State would not "have been * * * required to provide *medical assistance* to" respondents under its 1972 plan. Accordingly, the State was entitled under Section 1902(f) to deny coverage to respondents under its current plan.

2. The courts below also misconstrued the term "required" in Section 1902(f). That term, properly understood, refers to requirements imposed by federal statute and not to requirements arising solely out of state law. The State was "required" to provide medical aid to the respondent class by its 1972 general relief program, a portion of which

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[4]Respondents by definition were not categorically needy under the 1972 plan, and they apparently do not allege that they are medically needy. Whether an individual is medically needy depends upon two factors: satisfaction of the physical requirements for categorical assistance, and satisfaction of the financial standard of medical need established by the state. See Sections 1902(a) (10)(C) and 1905(a) of the Act. The State of Missouri has not extended medicaid coverage to the medically needy and therefore has had no occasion to establish a standard of medical need.

[5]The parties have stipulated that "[u]nder the approved Missouri State Plan for Medical Assistance in effect on January 1, 1972, * * * recipients of General Relief, were eligible for Medical Assistance" (Add. Stip. 2). But in view of the accompanying stipulation that the assistance was made without federal reimbursement (*ibid.*), it is clear that the term "Medical Assistance" was used there in its general, nonstatutory sense *i.e.*, as synonymous with "medical aid."

had been incorporated into its federally approved medical aid plan. But federal law required the State to provide medical assistance only to the categorically needy, not to the respondent class, and it is the federal requirement with which Congress presumably was concerned.

a. The structure and purpose of Section 1902(f) support the conclusion that the word "required," as there used, means "required by federal statute." The statute provides that "[n]otwithstanding any other provision" of Title XIX, no state "shall be required" to provide medical assistance to an individual "unless such State * * * would have been * * * required to provide" such assistance under its 1972 plan. The word "required" is used twice. The first use obviously refers solely to a federal statutory requirement: no state "shall be required [by this Act] to provide medical assistance * * * ." It is logical in this context to construe the second use also as referring to federal statutory requirements: "unless [under this Act] such State * * * would have been * * * required to provide medical assistance * * * ."

As thus construed, Section 1902(f) granted the State of Missouri the option to choose not to extend medicaid coverage to individuals, such as respondents, who were not categorically needy under the State's 1972 standards. This construction is consistent with the legislative purpose underlying the enactment of Section 1902(f). Congress understood that establishment of the supplemental security income program would increase the number of individuals considered to be "categorically needy" and that a requirement that the states provide medical assistance to the individuals newly added to that class could be burdensome. See S. Rep. No. 93-553, *supra*, at 56. Section 1902(f), as we construe it, enables the states, as Congress intended, to avoid this burden if they choose to do so.

b. Respondents contend (Br. in Op. 12), however, that the second use of the term "required" in the statute must mean required by the terms of the state's 1972 plan, because it is followed by the qualifying clause, "had its plan for medical assistance approved under this title and in effect on January 1, 1972, been in effect * * *." Respondents argue that if Congress had intended to refer only to a federal requirement, it would have been unnecessary to mention the state's 1972 plans.

Mention of the states' 1972 plans was necessary, however, because in 1972 the states were empowered to establish the need levels that defined the class of categorically needy entitled to federally funded medical assistance. The federal statute required medicaid coverage for the categorically needy, and it defined, by reference principally to physical attributes, a class of individuals who could be treated as categorically needy; but it left to the states the task, *inter alia,* of setting the standards of need that would determine which members of that class actually would be treated as categorically needy. There was therefore no comprehensive federal definition of "categorically needy," only a partial definition.

The states completed the definition in part by setting need standards responsive to local conditions. Thus the only way for Congress to refer to the class of individuals to whom the states were required to furnish medical assistance under prior federal law was by reference to the class of individuals to whom the states had been required to make payments by virtue of the need standards set forth in their separate plans.

3. Fifteen states have elected to limit medicaid coverage in accordance with Section 1902(f).[6] We are informed that the medicaid plans of at least ten of these states covered more

[6]In addition to Missouri, the states are Colorado, Connecticut, Hawaii, Illinois, Indiana, Minnesota, Mississippi, Nebraska, New Hampshire, North Carolina, Ohio, Oklahoma, Utah, and Virginia.

than just the categorically needy in 1972.[7] It does not appear, however, that any of those states will be directly affected by the outcome of this litigation. The problem presented by this case arises only when a state denies medicaid coverage to a categorically needy individual who would have received some form of medical aid under the state's 1972 medicaid plan. To the best of our knowledge none of the other states that has exercised the election under Section 1902(f) currently denies coverage to such individuals. Moreover, we are not aware of any similar litigation involving any other state. In these circumstances, we cannot say that the case presents an issue of sufficiently general importance to warrant this Court's review.

CONCLUSION

The petition for a writ of certiorari should be denied.

Respectfully submitted.

DANIEL M. FRIEDMAN,
Acting Solicitor General.

FEBRUARY 1977.

[7]The considerations relevant to the scope of the medicaid obligations of the majority of those states, which covered both the categorically needy and the medically needy but not others, will be different from those we believe to be controlling here, for those states would have received federal matching funds with respect to the medical payments made to all individuals covered by their 1972 plans. However, a holding that the State of Missouri is compelled to provide medical assistance to all categorically needy individuals who would have received benefits under its 1972 plan would appear to apply to the other states as well.